Public Health
Prevent. Promote. Protect.
Trumbull County

1st Dose ☐
2nd Dose ☐
Booster ☐

Pfizer 6mo-4y ☐
Pfizer 5-11y ☐
Pfizer 12 & up ☐
Moderna ☐
J&J ☐

COVID- 19 Vaccine Administration Record

This record will be kept on file at the Trumbull County Combined Health District. It acknowledges that the person has read and/or understands information about the Covid-19 vaccination.

Please Print Clearly:

First Name: _____ Last Name: _____

Date of Birth: _____ AGE: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: MALE or FEMALE Phone: _____

Race: White African American Asian Hispanic American Indian Other

1.	Are you Sick Today? (Fever, Congestion, etc.)	NO	YES
2.	Have you been diagnosed with Covid-19 in the past 30 days	NO	YES
3.	Are you Pregnant?	NO	YES
4.	Are you Breastfeeding?	NO	YES
5.	Have you ever had an allergic reaction to an immunization?	NO	YES
6.	Do you have a history of Anaphylaxis? (Severe Allergic reactions)	NO	YES

IF YES PLEASE EXPLAIN: _____

I have received a copy and have read or had read to me the information contained in the appropriate Vaccine Information Statement(s) or EUA in my primary language about the disease(s) and vaccine(s) checked above. I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) indicated on this record be given to me or the person named above for whom I am authorized to make this request. I also grant permission for this record to be released to medical providers, health departments, schools, daycare centers, community and state immunization registry databases. I have seen or received a copy of the Notice of Privacy Practices for The Trumbull County Combined Health District and have had a chance to ask any questions concerning this.

Patient/Parent/Guardian Signature _____ Date _____

Clinic Use Only:

Clinic Name: Trumbull County Combined Health District Clinic

Address: 176 Chestnut Ave. NE, Warren, Ohio 44483

Date administered:

Injection Site: LA RA **Administered by:**

Vaccine Manuf.:

Exp. date:

Lot No#: